Legal Issues

By William C. Wilson, Esq.

The Legal Implications of Family Expectations

Dr. B. was an 88-year-old resident of a skilled nursing facility, a highly educated veteran of two wars who had had a successful medical practice until his retirement. His admitting diagnoses included stage 4 metastatic prostate cancer, for which he had refused chemotherapy. He was admitted to the skilled nursing facility for physical and occupational therapy after hip arthroplasty that was necessitated by a fall at home.

Dr. B. was competent to make decisions, but his daughter and son were very involved in his medical decision-making. His daughter, Ms. L., visited her father every day and took it upon herself to provide her father with ancillary care.

One day, Dr. B. was in his wheelchair. A certified nurse assistant (CNA) asked him if he wanted to return to bed, but Dr. B. refused. The CNA left the room. Approximately a half hour later, a different CNA found Dr. B. on the floor.

He had hit his head on the bedframe and suffered a dislocation of the recently repaired hip. He was transferred to a hospital and underwent another hip arthroplasty. Ten days later, Dr. B. died.

Ms. L. and her brother, Mr. B., sued the facility for wrongful death, elder neglect, violation of patients' rights, and negligence. When both plaintiffs were deposed, they denied knowledge of their father's cancer and that he had been placed on palliative care. The plaintiffs also said that they felt it was "common sense" that their father have a "lap buddy" restraint across the front of his wheelchair every time he was in it, despite the fact there was no order for a lap buddy. Plaintiffs said that other facility residents had lap buddies and that a staff member had made off-the-cuff remark that "everyone" had lap buddies.

The facility chart was almost devoid of legible progress notes describing the interactions between the clinicians and the family regarding Dr. B.'s diagnoses, course of stay, restraints, and prognosis.

The case was settled, but its terms are confidential.

Role of the Clinician

Clinicians must manage polypharmacy, delirium, dementia, falls, osteoporosis, malnutrition, pressure sores, incontinence, and multiple, interacting comorbidities. Attending physicians have ultimate responsibility for the medical care provided to nursing home residents and must write appropriate orders taking all these comorbidities into account.

Clinicians must assess (with the assistance of the nursing staff) behavioral changes, cognition, affect, gait, and overall physical function in order to maintain or improve functional outcomes. This must all occur with the knowledge that the clinicians are not at the facility 24/7. Thus, they must rely heavily on facility nursing staff as their eyes and ears.

Communication is paramount not only between clinicians and nursing staff but also between clinicians and family members, especially when a resident is incompetent. Families need to know what to expect during their loved one's stay at a facility. Clinicians should ask families to participate in establishing care goals and expectations for the frequency of medical follow-up with their loved one.

Transparency is a key to avoiding future complaints and litigation. Perhaps, if the clinicians caring for Dr. B. had communicated the severity of his comorbidities to his adult children, and had spoken with them about the lap buddy issue, no suit would ever have been filed.

Family Involvement, Outcomes

Communication with families is not simply good practice in general; it is required by F tags 151, 152, and 154. Several interventions have been designed to encourage and facilitate more family involvement.

For example, researchers in the early 1990s tested whether family involvement in the delivery and planning of care would have positive effects on nursing home residents with dementia. At the end of the study, family members reported better relations with residents and indicated that they responded more favorably to family visits. The researchers also found that medications were more likely to be reduced for the residents with family involvement than in others (J. Gerontol. Nurs. 1992;18[7]:19–25).

Researchers at the University of Iowa designed the Family Involvement in Care program to include education sessions for families, as well as written agreements between the families and staff on the care of residents. At the end of a 9-month trial, family members reported increases in the consideration and physical care that staff provided to residents, as well as fewer feelings of loss associated with placing a loved one in a nursing facility (Final Report RO1NR01689, University of Iowa, Iowa City; 2000).

The Partners in Caregiving program created councils and support groups for family members and engaged staff and administration to change facility policy for better facility culture. Evaluations of various workshops in communication, listening skills, and group discussions showed high satisfaction among both family members and staff. Families of dementia residents indicated less conflict with staff, and staff members were less likely to quit their jobs (Gerontologist 1998;38[4]:499–503).

Although none of these studies evaluated the effect of better communication between staff and family members on the latter's litigiousness, it is reasonable to conclude that the more satisfied a family is with care, the less willing it will be to sue a facility. These studies also suggest that better communication between families and staff increases the quality of life for residents.

Talk Things Through

Dr. B.'s medical chart documented conversations between Ms. L. and the facility's social worker wherein Ms. L. expressed surprise at her father's death. Ms. L. was under the impression that her father was progressing and was going to return home. This conversation does not reflect the physician's note written approximately 13 days prior to Dr. B.'s death, discharging Dr. B. from physical therapy due to the fact that he had not been progressing.

Ms. L.'s surprise at her father's death also does not reflect the fact that her father was diagnosed with "failure to thrive," cachexia, and severe protein malnourishment. All clinical indicators were pointing toward imminent death, yet it appeared the family was not aware of their father's grave condition.

The plaintiffs were both well-educated adults. They were capable of understanding the details of their father's illness and his poor prognosis. If any substantive conversation took place between the clinicians and the family, the facility chart did not reflect those conversations. The clinicians should have taken a more proactive role in managing the family's expectations.

Physicians should understand:

- Federal regulations require that nursing facilities provide residents and their legal representatives with their physician's name, specialty, office address, and telephone number.
- Physicians are required to respond to calls from residents and their representatives to discuss the resident's medical care.
- It is important for physicians to contact families at critical times during a nursing facility stay, besides at admission and the end of life, and approach families with sensitivity and compassion, particularly at these difficult times.
- Physicians should communicate with family members and resident representatives as significant changes in medical condition occur.

Although it is never guaranteed that increased communication between a clinician and a resident or family will avert litigation, it is a reasonable proposition that the better the communication about diagnoses and prognosis, the more in line family expectations will be with the care and treatment provided to the resident and with reality.

This column is not to be substituted for legal advice. William C. Wilson *is a partner in the law firm Wilson Getty, LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.*

Medical Expert Perspective

Unrealistic expectations on the part of our residents and their families are at the root of much dissatisfaction and mistrust. In some situations, they will contribute to legal or regulatory actions.

Some of these bad outcomes can be prevented or reduced with good communication, patient and family education, and empathy. It's important that we empower and encourage all staff – not just doctors and other clinicians – to communicate realistic goals of care, along with a caring attitude, to our residents. And all clinicians and staff should take care not to make statements critical of other health care providers (inside the institution or elsewhere).

Physicians may not always take the time to communicate important information to our patients and their families, for reasons including fear of unpleasant interactions and our own discomfort discussing a bad prognosis or end-of-life issues.

It's a great idea for an attending clinician to make contact with a new resident's family (with permission, of course) upon admission and to give them your contact information – and actually be available when called. These small measures can yield great results in good faith and appreciation.

This column highlights the importance of taking the time to discuss diagnoses, prognoses, expectations, and goals so that patients understand their medical condition (to the extent they want to) and what to reasonably expect.

—Karl Steinberg, MD, CMD, Editor in Chief